



**BlueCrossBlueShield  
of North Carolina**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

To: Dental Blue Select Customer Service  
Attn: Enrollment  
P. O. Box 2400  
Winston-Salem, NC 27102

From: Subscriber Name: \_\_\_\_\_ Subscriber Id: \_\_\_\_\_

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City: \_\_\_\_\_, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Re: Your Student Dependent: Name: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Member's Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ]

Group Number: \_\_\_\_\_ (See your Dental Id Card)

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**VERIFICATION OF FULL-TIME STUDENT STATUS**

1. Is the above member a full-time student? Yes \_\_\_\_ No \_\_\_\_

2. If YES, please provide the following information:

a. Name of School \_\_\_\_\_

b. Street Address/P. O. Box \_\_\_\_\_

c. City, State, Zip \_\_\_\_\_

d. Graduation Date \_\_\_\_\_

(Month) (Day) (Year)

3. Please mail the signed and completed form to:

**Dental Blue Select Customer Service**

**Attn: Enrollment Dept**

**P. O. Box 2400**

**Winston-Salem NC 27102**

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Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_